Keck Medicine of USC

LOS ANGELES FETAL SURGERY

TWIN-TWIN TRANSFUSION SYNDROME (TTTS) / SELECTIVE INTRAUTERINE GROWTH RESTRICTION (SIUGR) REFERRAL FORM

DATE _____/_____/_____

PATIENT NAME _____ **DOB** _____/_____/_____
(Last) (First) (Middle)

PATIENT CELL PHONE (_____) _____-_____ **EDC** ____/____/____ **EGA** _____ **WEIGHT** _____

INSURANCE _____ **INSURANCE ID#** _____

REFERRING MFM _____ **MFM CELL PHONE** (_____) _____-_____
(First) (Last) (Title) (Optional)

MFM OFFICE PHONE (_____) _____-_____ **MFM OFFICE FAX** (_____) _____-_____

MFM OFFICE ADDRESS _____
(Street) (Suite #) (City) (State) (Zip Code)

PRIMARY OB _____
(First) (Last) (Title)

OB OFFICE PHONE (_____) _____-_____ **OB OFFICE FAX** (_____) _____-_____

OB OFFICE ADDRESS _____
(Street) (Suite #) (City) (State) (Zip Code)

DIAGNOSIS

☐ TTTS - Monochorionic twin pregnancy with maximum vertical pocket **≤ 2cm** in the Donor and **≥ 8cm** in the Recipient. The Donor may or may not have a visible bladder. Size discordance is not necessary.

☐ SIUGR - One fetus is **< 10th percentile** while the other fetus is appropriately grown (AGA). Although amniotic fluids may be discordant, they do not meet the criteria for TTTS (≤ 2cm and ≥ 8cm). Our protocol for laser surgery for SIUGR requires **absent or reverse flow** in the umbilical artery.

ULTRASOUND **DATE** ____/____/____

PLACENTA LOCATION ☐ Anterior ☐ Posterior ☐ Fundal

MULTIPLES ☐ Twins ☐ Triplets ☐ Quadruplets

CHORIONICITY ☐ Mono/Di ☐ Mono/Mono ☐ Other: _____

AMNIOTIC FLUID Maximum Vertical Pocket in each sac: Recipient _____ cm Twin ◯A or ◯B *(select one)*
Donor _____ cm Twin ◯A or ◯B

FETAL WEIGHT EFW Measurements: Recipient _____ grams _____%
Donor _____ grams _____%

FETAL BLADDER Donor fetus urinary bladder: ☐ Filling ☐ Not Filling

		RECIPIENT	DONOR
FETAL HYDROPS	Scalp / Skin Edema	☐ Yes ☐ No	☐ Yes ☐ No
	Pleural Effusion	☐ Yes ☐ No	☐ Yes ☐ No
	Pericardial Effusion	☐ Yes ☐ No	☐ Yes ☐ No
	Ascites	☐ Yes ☐ No	☐ Yes ☐ No
DOPPLER STUDIES	Umbilical Artery: AEDV	☐ Yes ☐ No	☐ Yes ☐ No
	REDV	☐ Yes ☐ No	☐ Yes ☐ No
	Umbilical Vein - Pulsatile Flow	☐ Yes ☐ No	☐ Yes ☐ No
	Ductus Venosus - Reverse Flow	☐ Yes ☐ No	☐ Yes ☐ No

CERVICAL LENGTH Cervical length _____ cm

Has a cerclage been performed? ☐ Yes ☐ No

FETAL ANOMALIES ☐ Yes ☐ No Comments _____

GENETIC SCREENING

1st Trimester ☐ Yes ☐ No Results: _____

NT ☐ Yes ☐ No Results: _____

2nd Trimester ☐ Yes ☐ No Results: _____

NIPT ☐ Yes ☐ No Results: _____

DIAGNOSTIC TESTING

CVS ☐ Yes ☐ No Date ____/____/____ Results: _____

Amniocentesis ☐ Yes ☐ No Date ____/____/____ Results: _____

PRETERM LABOR

Has this patient experienced any symptoms of preterm labor? ☐ Yes ☐ No

Have any medications for preterm labor been administered? ☐ Yes ☐ No

List: _____

AMNIOREDUCTION

Has an amnioreduction been performed? ☐ Yes ☐ No

Date ____/____/____ Volume extracted _____ mL

Date ____/____/____ Volume extracted _____ mL

MEDICAL HISTORY

Is the patient taking Aspirin? ☐ Yes ☐ No

Please list any pertinent maternal medical conditions _____ __

_____

PLEASE FAX FORM TO: (626) 356-3379

PLEASE ATTACH:

- Patient demographic information
- Insurance information
- Prenatal records
- Recent consultation letters and ultrasounds reports

Please contact our office at (626) 356-3360 if you need help with the insurance authorization process.

Arlyn Llanes, RN and Kris Rallo, RN are available to answer questions by phone at (626) 356-3360 or by email at Arlyn.Llanes@med.usc.edu or Kristine.Rallo@med.usc.edu.